SOUTH DAKOTA BOARD OF NURSING
SOUTH DAKOTA DEPARTMENT OF HEALTH
4305 S. Louise Avenue Suite 201 ♦ Sioux Falls, SD 57106-3115
(605) 362-2760 ♦ FAX: 362-2768 ♦ doh.sd.gov/boards/nursing

RN & LPN NURSE LICENSURE BY ENDORSEMENT

South Dakota joined the Nurse Licensure Compact January 1, 2001. If your primary state of residence (where you hold a driver's license, pay taxes, and/or vote) is also a Compact State, you are not eligible for RN or LPN licensure in South Dakota. For more information, or to check the status of your state, see www.ncsbn.org.

Please follow instructions carefully to avoid delays in processing your application. You can expect that it will take 3-6 weeks before all forms are received by this Board office so that your application can be considered for approval. Applications for licensure are maintained for one year only; all fees are non-refundable.

1. APPLICATION AND FEES

- Complete Application for Licensure by Endorsement Form 1.
- The licensure fee payment of $100 should be made out to South Dakota Board of Nursing. If a Temporary Permit is also desired, see step 5 below.

2. VERIFICATION OF LICENSURE

- Complete Part I of Form 2 and send it to the office of the Board of Nursing in the state in which you were originally licensed as a nurse. To expedite the process, contact that Board of Nursing to determine whether you should enclose a fee with Form 2. That Board will return the completed form directly to the South Dakota Board of Nursing.
- If your original state of licensure requires licensure verification through NURSYS, please use the online verification process available at www.nursys.com. You may use the same link to see a list of participating states.

3. VERIFICATION OF EMPLOYMENT

- To obtain or retain an active nursing license, you must provide verification of nursing employment or volunteer work of at least 140 hours in any 12-month period, or an accumulated total of at least 480 hours, within the preceding 6 years. If you are unable to provide verification, contact the Board concerning a Nurse Refresher Course.
- Complete the top portion of Form 3 and send it to your employer(s)/former employer(s) for verification. The completed form will be returned directly to the South Dakota Board of Nursing.

4. REQUEST FOR TRANSCRIPT

Complete Form 4 and send it to the Office of Registrar of the nursing education program which prepared you for initial licensure. An official transcript, not a copy, is required. Contact your Registrar's office to determine whether you should enclose any fee with Form 4.

5. CRIMINAL BACKGROUND CHECK

You must use fingerprint cards that are provided to you by the South Dakota Board of Nursing office. To request that fingerprint materials be mailed to you, please call the Board of Nursing (605) 362-2760 or send your request via email to Jill.Vanderbush@state.sd.us. The processing fee for the criminal background check is $43.25 and should be made payable to South Dakota Division of Criminal Investigation (DCI).

6. TEMPORARY PERMIT APPLICATION

A Temporary Permit is required before you can begin orientation or practice nursing while awaiting licensure. The Temporary Permit is issued for one 90-day period and is not renewable. All fees are non-refundable.
A Temporary Permit may be issued by the South Dakota Board of Nursing upon receipt of all of the following:

Form 1: Application for Licensure by Endorsement with $100 fee
Form 5: Temporary Permit Application with $25 fee
Photocopy of a current LPN or RN license bearing an expiration date
Completed Criminal Background Check fingerprint cards

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APPLICATION FOR LICENSURE BY ENDORSEMENT: FORM 1 – PG 1 OF 2

All information on this form is to be completed by the Applicant.
Please type or print in black ink. Note: Fees are non-refundable.

I. DEMOGRAPHIC DATA

CURRENT LICENSURE:	**LPN**	**RN**				

NAME: _____
First Name Middle Name Maiden Name Last Name Other(s):

PRESENT ADDRESS: _____
Street or PO Box City State Zip

MAILING ADDRESS: _____
Street or PO Box City State Zip

HOME TELEPHONE:	OTHER TELEPHONE:	EMAIL:

DATE OF BIRTH:	❒Male ❒Female	US CITIZEN: ❒Yes ❒No	SS#

❒Caucasian ❒Black ❒Hispanic ❒Asian or Pacific Islander ❒American Indian or Alaskan Native ❒Other:

II. PRELIMINARY EDUCATION

	INSTITUTION NAME & LOCATION	DATES ATTENDED	YEAR OF GRADUATION	DEGREE GRANTED
HIGH SCHOOL OR EQUIVALENT				❒Diploma ❒GED
COLLEGE OR UNIVERSITY (NON-NURSING)				

III. PROFESSIONAL EDUCATION

	INSTITUTION NAME & LOCATION	DATES ATTENDED	DATE OF GRADUATION (MM/DD/YYYY)	DEGREE GRANTED
BASIC PROGRAM IN NURSING				
ADDITIONAL NURSING EDUCATION				
ADDITIONAL NURSING EDUCATION				

IV. LICENSURE HISTORY

STATE	LICENSURE		LICENSE #	YEAR ISSUED	EXPIRATION DATE
ORIGINAL STATE:	❒RN	❒LPN			
OTHER STATE:	❒RN	❒LPN			
OTHER STATE:	❒RN	❒LPN			
OTHER STATE:	❒RN	❒LPN			

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APPLICATION FOR LICENSURE BY ENDORSEMENT: FORM 1 – PG 2 OF 2

V. DISCIPLINARY INFORMATION			
1.	Have you ever been convicted, pled no contest/nolo contendere, pled guilty to, or been granted a deferred judgment or suspended imposition of sentence with respect to a felony, misdemeanor, or petty offense other than minor traffic violations? **If YES, provide a signed and dated explanation. You must also submit copies of charges or citations and All communication with (to and from) the citing agency AND the court of jurisdiction, including evidence of completion/compliance with court requirements.**	❒YES	❒NO
2.	Is there any pending criminal prosecution against you which would constitute a felony?	❒YES	❒NO
3.	Are you currently being investigated or is disciplinary action pending against any professional license(s) or certificate(s) held by you?	❒YES	❒NO
4.	Has any nursing license or certificate ever held by you in any state or country been denied, revoked, suspended, stipulated, placed on probation, or otherwise subjected to any type of disciplinary action?	❒YES	❒NO
5.	Have you ever had privileges revoked, reduced, or otherwise restricted at any hospital or other healthcare provider entity?	❒YES	❒NO
6.	Have you ever been subject to proceedings by a professional society to revoke, reduce, or restrict membership?	❒YES	❒NO
7.	Have you ever been treated for abuse or misuse of any alcohol or chemical substance?	❒YES	❒NO
8.	Have you ever experienced a physical, emotional, or mental condition that has endangered the health or safety of persons entrusted in your care?	❒YES	❒NO
9.	Do you currently owe child support arrearages in the sum of $1,000 or more?	❒YES	❒NO
For 2-9 above, provide an explanation for each YES response on a separate piece of paper, with a complete description of dates and circumstances. You must also send ALL supporting applicable documents.			

VI. EMPLOYMENT

List your last six years of nursing employment. If you have not worked in nursing, please explain.

DATES OF EMPLOYMENT	INSTITUTION	CITY/STATE
FROM: TO:		
FROM: TO:		
FROM: TO:		
FROM: TO:		

VII. DECLARATION OF PRIMARY STATE OF RESIDENCE – AND - AFFIDAVIT

I declare that my primary state of residence (where I hold a driver's license, pay taxes, and/or vote) is:

_____

This is my "home state" under the Nurse Licensure Compact
and is my "declared fixed permanent and principal home for legal purposes."

I further declare and affirm under penalties of perjury that this application for nurse licensure in South Dakota has been examined by me and, to the best of my knowledge and belief, is in all things true and correct.

_____ _____

APPLICANT SIGNATURE DATE

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VERIFICATION OF LICENSE: FORM 2 - PG 1 OF 2

Complete Part I, then send this form to the Board of Nursing in the state where you were originally licensed. Most states charge a fee for verification of licensure; to save processing time, contact that state Board of Nursing to determine the appropriate fee to enclose with this form.

PART I: TO BE COMPLETED BY APPLICANT; FORWARD TO ORIGINAL STATE OF LICENSURE

NAME: _____
First Middle Maiden Last Other(s):

ADDRESS: _____
Street or PO Box City State Zip

HOME TELEPHONE:	OTHER TELEPHONE:	EMAIL:
DATE OF BIRTH:	SS#	

NURSING EDUCATION PROGRAM:	Institution:	Degree Granted:
	Location:	Date of Completion:

NAME AS IT APPEARS ON ORIGINAL LICENSE:

STATE	TYPE		LICENSE #	ISSUE DATE	EXPIRATION DATE
ORIGINAL STATE OF LICENSURE:	❒RN	❒LP/VN			
CURRENT STATE OF LICENSURE:	❒RN	❒LP/VN			
OTHER STATE:	❒RN	❒LP/VN			
OTHER STATE:	❒RN	❒LP/VN			
OTHER STATE:	❒RN	❒LP/VN			
OTHER STATE:	❒RN	❒LP/VN			

I authorize the _____ Board of Nursing to furnish to the South Dakota Board of Nursing the information requested on page 2 of this form.

SIGNATURE: _____ DATE: _____

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VERIFICATION OF LICENSE: FORM 2 - PG 2 OF 2

PART II: TO BE COMPLETED BY ORIGINAL STATE OF LICENSURE AND FORWARDED TO THE SOUTH DAKOTA BOARD OF NURSING			
THIS IS TO CERTIFY THAT (APPLICANT NAME):			
WAS ISSUED LICENSE #		TYPE:	❒Registered Nurse
DATE ISSUED:	EXPIRATION DATE:		❒Practical/Vocational Nursing
LICENSED BY:	❒Examination	❒Endorsement	❒Waiver
CURRENT STATUS:	❒Active	❒Inactive	❒Lapsed
HAS THE LICENSE EVER BEEN ENCUMBERED (DENIED, REVOKED, SUSPENDED, SURRENDERED, LIMITED, PLACED NO PROBATION)?			❒YES ❒NO

IS DISCIPLINARY ACTION PENDING? ❒YES ❒NO If "YES", please provide explanation:

GRADUATED FROM: ❒10th Grade ❒High School ❒High School Equivalency (GED)				
NURSING EDUCATION PROGRAM COMPLETED:	INSTITUTION:		TYPE OF PROGRAM	
	LOCATION:	DATE GRADUATED:	❒DIP	❒LPN
			❒AD	❒Other:
			❒BSN	

STATE BOARD TEST POOL EXAMINATION							NCLEX	
	REGISTERED NURSE					LPN/VN	RN	LPN
TEST	Medical Nursing	Psychiatric Nursing	Obstetric Nursing	Surgical Nursing	Nursing of Children	Date passed	Date passed	Date passed
SCORE								
SERIES/ FORM #								

SIGNATURE _____

SEAL

TITLE _____

STATE _____ DATE _____

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VERIFICATION OF EMPLOYMENT: FORM 3 - PG 1 OF 1

To obtain/retain active status license, the applicant must provide verification of employment in nursing within the previous six years of at least 140 hours in any 12-month period OR an accumulated 480 hours. If you have not worked or volunteered the required number of hours in nursing and wish to obtain a license, contact the SD Board of Nursing for more information.

APPLICANT: COMPLETE THIS SECTION AND FORWARD THE FORM TO YOUR EMPLOYER(S) OR FORMER EMPLOYER(S). THIS FORM MAY BE DUPLICATED FOR ADDITIONAL VERIFICATIONS. RETURN THE COMPLETED FORM(S) TO THE SOUTH DAKOTA BOARD OF NURSING.

NAME: _____
First Middle Maiden Last Other(s):

ADDRESS: _____
Street or PO Box City State Zip

SS#

❒ I have been employed/volunteered as a ❒RN / ❒LPN within the last six years.

❒ I have not been employed as a nurse within the past six years.

I hereby request and authorize my employer/former employer to release the information requested on this form to the South Dakota Board of Nursing for Licensure purposes.

_____ _____
SIGNATURE OF APPLICANT DATE

THIS SECTION TO BE COMPLETED BY EMPLOYER
(PROVIDE EMPLOYMENT HOURS WITHIN THE LAST 6 YEARS)

The above-named individual (was) employed/volunteered as a nurse	From:	To:
	Total hours worked in this period:	

I, the undersigned, declare and affirm that, according to our records and to the best of my knowledge and belief, the information provided above for purpose of licensure is true and correct.

_____ _____
SIGNATURE OF AGENCY REPRESENTATIVE/TITLE DATE

NAME OF EMPLOYER:

ADDRESS OF EMPLOYER:

TELEPHONE:	EMAIL:

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REQUEST FOR TRANSCRIPT: FORM 4 - PG 1 OF 1

APPLICANT: PLEASE FILL OUT THE INFORMATION REQUESTED BELOW AND FORWARD THIS FORM TO THE OFFICE OF THE REGISTRAR FROM YOUR NURSING EDUCATION PROGRAM.

NAME: _____
First Middle Maiden Last Other(s):

ADDRESS: _____
Street or PO Box City State Zip

DATE OF GRADUATION: | SS#

I am requesting that an official transcript (must bear raised or color coded school seal) of my nursing education be attached to this request and forwarded to the South Dakota Board of Nursing for licensing purposes.

_____ _____
SIGNATURE OF NURSE APPLICANT DATE

REGISTRAR: PLEASE ATTACH THIS FORM TO THE OFFICIAL NURSING TRANSCRIPT AND SEND TO THE SOUTH DAKOTA BOARD OF NURSING AT THE ADDRESS BELOW.

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TEMPORARY PERMIT BY ENDORSEMENT: FORM 5 - PG 1 OF 1

APPLICATION FOR ❒RN ❒LPN

APPLICANT: COMPLETE ALL QUESTIONS; INCOMPLETE APPLICATIONS WILL BE RETURNED.

- TEMPORARY PERMITS ARE ISSUED FOR A PERIOD OF 90 DAYS, AND ARE NOT RENEWABLE.
- SOUTH DAKOTA LAW PROHIBITS THE PRACTICE OF NURSING WITHOUT A VALID SOUTH DAKOTA LICENSE OR TEMPORARY PERMIT.
- A TEMPORARY PERMIT OR VALID LICENSE IS REQUIRED BEFORE YOU BEGIN ORIENTATION AT YOUR PLACE OF EMPLOYMENT.

THIS APPLICATION MUST BE ACCOMPANIED BY ALL THREE:

1. A photocopy of a current RN or LPN license with expiration date, from any U. S. state or territory
2. Form 1 – Application for Licensure by Endorsement
3. Fees: $100 fee for endorsement + $25 fee for temporary permit = $125
4. Fingerprint Cards for Criminal Background Check and processing fee of $43.25

NAME: _____
First Middle Maiden Last Other(s):

ADDRESS: _____
Street or PO Box City State Zip

SCHOOL OF NURSING: Institution: _____
Location: _____

INDICATE WHICH LICENSURE EXAMINATION YOU HAVE WRITTEN:

❒State Board Test Pool Exam (SBTPE) (Prior to July 1982)	State where exam was written:	Year exam was written:
❒National Council Licensure Exam (NCLEX)	State where exam was written:	Year exam was written:
❒Canadian Nurses' Association Testing Services Exam	State where exam was written:	Year exam was written:
❒Other:	State where exam was written:	Year exam was written:

I will be employed by (Institution): _____
Address: _____
I will begin employment on (date): _____

The RN applicant for licensure by endorsement into South Dakota who has been issued a temporary permit is required to use the initials **"RN App"** (Registered Nurse Applicant).
The LPN applicant for licensure by endorsement into South Dakota who has been issued a temporary permit is required to use the initials **"LPN App"** (Licensed Practical Nurse Applicant).

I certify that all information provided on this application is true to the best of my knowledge and belief.

_____ _____
SIGNATURE OF APPLICANT DATE